Written Testimony of Allen S. Lichter, MD

on behalf of

The American Society of Clinical Oncology

before the

Health Subcommittee

of the

Ways and Means Committee

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Thank you for the opportunity to submit written testimony for consideration by the House Ways and Means Health Subcommittee on programs that reward physicians for delivering high quality and efficient care. My name is Allen Lichter. I am Chief Executive Officer of the American Society of Clinical Oncology (ASCO) headquartered in Alexandria, Virginia. As a clinician and leader of the professional organization for physicians who treat people with cancer, I am submitting comments about Medicare payment reform in the context of cancer care and the critical link between such efforts and robust quality assessment systems. ASCO and our members have been active over the past decade in developing, supporting and participating in a robust quality assessment program that promotes high quality, high value cancer care.

If current trends continue, the nation will face ongoing, unsustainable increases in the costs of cancer care. There will be an estimated 2.3 million new cancer cases each year in the United States by 2030, and the National Cancer Institute has projected the population of cancer survivors—numbering 13.8 million in 2010—will grow to over 18 million by 2020. The care needs of cancer patients and survivors will likely exceed the capacity of the oncology workforce, which is projected to experience a nearly 30% shortfall in the supply of oncologists by 2020. All health care payers will confront the consequences of increasing cancer prevalence and costs, but as the dominant payer for elderly Americans with cancer diagnoses, Medicare faces perhaps the greatest challenge. Over half of all new cases of cancer are diagnosed in individuals who are 65 years or older.

Payers obviously are not the only group concerned about the cost of cancer care. Our patients, even those with insurance, are faced with burdensome out-of-pocket expenses. A national survey of cancer patients and family members showed that, among those with insurance, 25% reported that they

consumed all or most of their savings dealing with cancer, and 33% reported a problem paying cancer bills. A majority of oncologists report concerns regarding patients' out-of-pocket spending. In the face of projected increases, the financial burden placed on cancer patients and their families is unacceptable and unsustainable.

The increasingly challenging economic environment—and a flawed payment system—have also strained the nation's network of community based oncology practices, where the majority of cancer care occurs. Over 200 practices have either closed their doors or reduced service because they are unable to absorb the escalating cost of providing services in the context of a payment system that inadvertently penalizes those who invest in providing high quality, cost-effective care. The administrative burdens placed on these practices by the health system are growing exponentially, although typically these burdens do not result in meaningful enhancements in patient care or efficiency. Community based oncology practices provide critical access points where vulnerable cancer patients can obtain the care they need, and at the same time, community based oncology practices are extremely cost-effective in the delivery of this care. Over the past four decades, we have built an outpatient delivery system for cancer that is the envy of the world, and now as a nation, we need to act quickly to ensure that we do not lose this valuable resource.

In light of these challenges, ASCO and the oncology community have been working over the past decade to gather scientific evidence and develop strategies for improving the quality, value and efficiency of cancer care. In the remainder of these comments, I would like to describe the insights we have gained in working to address these important issues.

We have learned that significant improvements in cancer care delivery can be achieved by building upon the strengths of our existing delivery system, which relies on care provided in both the community-based physician office setting and the hospital-based outpatient setting. Policy changes that provide meaningful support for the provision of high quality, comprehensive care in these outpatient settings can bring immediate positive impacts on clinical outcomes and quality of life for cancer patients.

In taking systemic steps to improve cancer care, both patients and payers can benefit from significant efficiencies. In the area of cancer care, ASCO and our members are working with private payers and other stakeholders to pioneer approaches for treating cancer patients in the outpatient setting that avoid unnecessary emergency department visits, reduce unscheduled hospitalizations, smooth variation in care and place greater emphasis on selecting the most cost-effective drug therapies. Early results from these initial pilots—which marry practice efficiency and a strong emphasis on quality monitoring and assessment—have demonstrated significant potential for both savings and enhanced patient experiences.

To achieve the national goals of better health, enhanced quality of care, and lower costs within the uniquely complex context of patients with cancer, it is imperative that we implement a robust quality assessment system. Under virtually every type of payment reform designed to reward efficiencies in health care, it is critically important to provide safeguards that assure efforts to lower health care costs do not jeopardize access to high quality, high value care for elderly Americans with cancer. A strong, cancer-focused quality assessment program is vital to achieving this protection and must play a pivotal role in any payment reforms of the health care delivery system for cancer care.

Since 1999, efforts to enhance quality improvement have become central to ASCO's work; most notably, in the development and expansion of the Quality Oncology Practice Initiative (QOPI). This effort, designed to facilitate quality measurement and continuous improvement, is the only comprehensive, national database for oncology care in ambulatory settings, where the vast majority of cancer services are provided. Begun in 2002 by ASCO as a pilot project, QOPI became available to all ASCO member medical oncologists and their practices in 2006 as a free member benefit. Over the past decade, QOPI has grown from a pilot to a national initiative with over 700 registered practices submitting data on more than 25,000 patient records every six months. ASCO has developed, tested, and implemented more than 100 cancer-specific quality measures through the program. The process is designed to be nimble, allowing for rapid integration of quality measures based on new scientific guideline recommendations, IOM reports and other sources.

ASCO's experience with QOPI has revealed that, even in the absence of incentives beyond the opportunity to improve care, a significant number of medical oncologists are able and willing to devote time and resources to participate in a system that is designed to create meaningful improvements in the quality of cancer care. Participating practices report that QOPI has caused them to re-examine their work flow and policies, improve safety measures and focus on areas that demonstrate an opportunity for improvement. For example, when compared to newly enrolled practices, those completing multiple cycles of QOPI data collection demonstrated meaningful improvements in performance on measures involving pain management, which is one of the primary drivers for unplanned emergency department visits.

A growing number of private health plans have recognized the power of programs like QOPI. In 2007, Blue Cross Blue Shield of Michigan began a program to subsidize practice participation in QOPI. Other

plans have included special recognition in provider directories for QOPI practices and still others have offered other forms of recognition for QOPI participation, including increased economic rewards and relief from certain administrative requirements such as preauthorization.

ASCO's dedication to QOPI continues, as does the program's expansion. Additional disease modules and measures are in development. Tests of data reporting from electronic health records systems are underway. And most importantly, our members and their practices continue to sign on.

Quality measurement and improvement can only work to improve value if it is meaningful and relevant to providers in their efforts to provide the highest level of care to their patients—and does not simply represent one more administrative burden. Over the past few years, ASCO has reached out to national payers and to Medicare to urge adoption of programs and measures already developed by experts in relevant diseases. ASCO is increasingly concerned about the proliferation of disconnected programs arising from multiple payers—each with their own requirements and conditions. Not only is this unlikely to improve quality, it has a strong chance of harming it. Organizations like ASCO have invested in development of programs that have strong physician support—because they are part of building it—while at the same time providing the most challenging quality assessment program for oncology practitioners. Meaningful quality measurement in cancer requires a comprehensive set of clinically-meaningful and evidence-based measures. We understand that CMS has invested in PQRS; however, the complexity and rapidly evolving science around more than 100 diseases that comprise cancer require measurement that goes beyond that can be achieved through PQRS alone. We need a system that:

- Captures the full patient experience, from diagnosis and treatment to survivorship;

- Provides rapid insight into patient outcomes, including treatment response, side effects, patient compliance, and safety signals; and
- Supports patient and physician decision making about treatment choices across all stages of the disease.

QOPI provides a uniquely strong foundation—but ASCO recognizes our members and the oncology community will benefit from an initiative with even greater sophistication. In 2011, the ASCO board directed that immediate work begin on construction of a cutting-edge rapid learning system for oncology. The rapid learning health care concept is promoted as the ultimate goal in the Federal Health IT Strategic Plan, and is described as an "*environment where a vast array of health care data can be appropriately aggregated and analyzed, turning data into knowledge that can be put to immediate use. A learning health system can shorten the gap between the creation of new knowledge and its widespread adoption in health care from the often-quoted 17 years to 17 months, or even 17 weeks."*

Based on recommendations from an expert workshop convened by the Institute of Medicine, ASCO is leading the development of a system in which data routinely generated through care of cancer patients and cancer research feeds into a central databank or coordinated databases, triggering continuous innovation. This rapid learning system will be useful in preventing many quality issues from occurring with real time decision support, and will automate increasingly sophisticated quality reporting. Equally important, the same infrastructure will facilitate real-world studies of treatment effectiveness in patient populations that are common but rarely represented in clinical trials (*e.g.,* the elderly and patients with multiple comorbidities); it will allow for early adverse event identification, support many types of scientific research, and support studies of quality and health care disparities.

The potential power of an oncology RLS can be illustrated with the example of erythropoietin stimulating agents (ESAs). Based on studies demonstrating reduced need for blood transfusion in chemotherapy patients, the first of these agents was approved for oncology use in 1993. ESAs subsequently became a commonly used component of cancer supportive care during active treatment. Beginning in 2004, emerging safety concerns led to product label warnings. In 2007, additional studies suggesting negative effects on survival and disease progression caused the FDA and CMS to issue further product label warnings and to restrict coverage.

However, if we had access to data from an RLS at the time, with real-time capture of millions of clinical data points and patient outcomes, it is reasonable to conclude that we could have identified these safety signals by 2004, perhaps even earlier. If the use of ESAs from 2004 -2007 had been at levels seen between 2008 and 2011, the quality of health care provided to our patients would have been improved, and CMS could have saved more than $3 billion (assuming a conservative estimate of 6,000 practicing oncologists prescribing ESAs during these years).

Oncology is a logical and ripe area for the initial development and testing of an RLS because of the prevalence, seriousness, and costliness of cancer; the long tradition and integration of clinical oncology research; and the proliferation of investigational therapies. Consistent patient engagement in cancer, the acknowledged need for patient-centered care, and existing well-studied patient reported outcomes also position oncology to adopt such a care model. Importantly, transformation of oncology practices to fully integrate health information technology capabilities through a learning network can inform novel payment models that could provide incentives to enhance patient outcomes and reduce costs. Achieving a rapid learning system will be at the top of ASCO's priorities for the foreseeable future.

So, what are the next steps that we recommend?

ASCO has joined the rest of the medical community in calling for repeal and reform of Medicare's Sustainable Growth Rate (SGR) payment formula, which has not been able to properly consider treatment advances, promote quality or control costs. This payment system is at odds with the triple aim and the concept of value-based purchasing. ASCO recommends repealing and replacing the SGR with a value-based payment system, recognizing there must be a multi-year transition guided by a series of pilots that point to successful, scalable models.

Leverage the tremendous investment already made by leading specialty societies in registries, quality monitoring and measure development. In particular, in the area of cancer, build upon the emerging rapid learning system infrastructure and initiatives that ASCO is pursuing. We urge Congress and CMS to take steps that foster the development of a rapid learning system for cancer in a manner that is consistent with the Federal Health IT Strategy and the creation of care delivery systems that are ready-made for innovations. Taking advantage of lessons learned from proven and emerging programs, CMS should work with leading specialty societies to launch and test value-focused demonstration projects. In the area of oncology, ASCO is prepared to build on the work we have done in this area to improve the patient experience, not just for Medicare, but for all our patients.

Provide for fair and adequate payment levels for delivering oncology services that correlate with enhanced care and patient outcomes, including the provision of comprehensive outpatient services and treatment planning, which improve patient outcomes, reduce complications and promote the selection of efficient therapies.

Construct models that reward high performing physician practices with more favorable payment updates and relief from certain administrative requirements and burdens. The demands of today's practice environment call for significant investment to achieve required efficiencies, aggressive disease management and care coordination—all vital to both high quality care and continued economic survival. Practices making that investment should share in the savings they generate. Oncology care routinely involves services from as many as eight different types of providers and occurs across multiple practice settings. This complexity has evolved over time and presents a challenge to the traditional health system structure, both in the office based and hospital setting. Oncologists should be encouraged to make investments that can control the downstream costs of that complexity (e.g., emergency department visits, unplanned hospitalization, duplicate/unnecessary testing, etc.). Re-engineering care management, work flow, staffing and information technology to provide cost effective, high value care requires professional and financial investment—but an investment that offers significant return to the health care system, but most importantly to patients.

Chairman Herger, The American Society of Clinical Oncology stands ready to work with you and your colleagues to test new ideas, to share what we have learned through QOPI, and to continue progress towards a system that supports delivery of high quality care for every patient with cancer.